MAD RIVER COMMUNITY HOSPITAL
3800 JANES RD. P.O. BOX 1115
ARCATA, CALIFORNIA 95521
TELEPHONE: 707-822-3621

August 1, 1995

California Hospital Outcomes Project
c/o Ms. Andra Zach, RRA, MPH
Office of Statewide Health and Planning Development
717 K Street
Sacramento, CA 95814

RE: Acute Myocardial Infarction Review
August 26, 1990 through May 31, 1992

Dear Ms. Zach:

The Department of Medicine at Mad River Community Hospital has completed a comprehensive review of the 87 records identified in the *1994 California Hospital Outcomes Project*, a copy of which is enclosed. There were 16 deaths identified in the study of Acute Myocardial Infarction. Of those 16 deaths, 7 of the patients had been placed on a "Do Not Resuscitate" status. In accordance with AB 3639, these cases will not be included in future studies because outcome data would be considered defective. Further, we would like to draw your attention to the study recently reported by *U.S. News & World Report*, July 24, 1995 edition. Their study calculated mortality as the rate of patient deaths from admission to discharge rather than within 30 days (as per OSHPD) of discharge because from admission to discharge should more accurately relate the death to a quality of care issue.

A great amount of time and money has been spent by the hospital having physicians and staff review data that is, at best, 3 years old. The healthcare community would be far better served in the future by participating in relevant studies. Another issue of concern is the assumption made by the Office of Statewide Health Planning and Development that resource constraints associated with caring for uninsured patients may lead to worse care. This is not only presumptuous, it is definitely not a practice at Mad River Community Hospital.

Sincerely,

Douglas A. Shaw
Vice President

DAS:lm

Enclosure

MAD RIVER COMMUNITY HOSPITAL
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July 28, 1995

California Hospital Outcomes Project
c/o Ms. Andra Zach, RRA, MPA
Office of Statewide Health and Planning Development
717 K Street
Sacramento, CA 95814

RE: Acute Myocardial Infarction Review
August 26, 1990 through May 31, 1992

Dear Ms. Zach:

The Department of Medicine at Mad River Community Hospital would like to respond to the recent notification of "higher than expected" mortality reported in the Acute Myocardial Infarction Study of August of 1990 through May of 1992. Our small community hospital was reported to have an excessive number of deaths during this period with a total of 87 cases of myocardial infarction that were included in the study. There were 16 reported deaths according to the statistics reported to us. This was felt excessive and beyond the expected number of deaths given state-wide experience and for this reason, a question of management is of course raised. For this reason, the Department of Medicine took it upon itself to review all 87. In evaluating the discharge coding, we found 4 patients in the group that expired that we felt were miscoded and 2 in the group that did not expire. In these 6 cases, acute myocardial infarction was not the primary diagnosis. This would bring the total number of deaths secondary to myocardial infarctions down to 12 from 16 and the total number of myocardial infarctions down to 81. This may well, in and of itself, remove Mad River Community from "out of expected" range.

We would also like to point out that there are some unique features of this hospital that may well change the statistical outcome. First of all, our hospital has an extremely large catchment area in that we receive ambulances from two counties and also receive transfers from another non-acute care clinic institution in Hoopa, California which itself has a relatively large catchment area. For this reason, many of our cases have a quite long ambulance transport time and we noted on our review that in a number of cases management would be considerably different had patient arrived at the institution sooner, especially with regard to the institution of thrombolytic therapy which can have a significant effect on outcome. Also, a number of patients were noted to have experienced cardiopulmonary arrest during transport and the prolonged transport times, of course, significantly impacted on outcome. In this regard, of the 16 deaths we did note that 5 arrived in our Emergency Room after out-of-hospital codes and were resuscitated to

cardiac activity only and were subsequently pronounced brain dead within hours to a few days of admission after appropriate neurologic followup. It was felt on review that these 5 patients were essentially brain dead on admission. Two patients had cardiopulmonary resuscitation instituted in the field with it continuing during ambulance transfer.

We would ask that you please review your findings with the above information in mind and reconsider placing us in your "higher than expected" mortality category.

Thank you very much for your attention.

Christopher E. Lee, M.D.
Member
Department of Medicine

CEL:lm
cc: Michael J. Young
Administrator.